have inventories of vaccine intended for public clinics. Some of the vaccines have been purchased with state funds and some with federal grants from the CDC. CDC had set aside the appropriate amount of excise tax from vaccine grants, assuming the tax would be reinstated soon. It has been estimated that a state's tax liability could reach $3 million at a time when states are cash-strapped for basic services. Dr. Walter Orenstein, Director of the CDC's National Immunization Program, said the CDC was not consulted and that "this may create one more impediment to raising immunization rates."

FROM: ***American Medical*** News. September 13, 1993.

## States Get Funding for TB Treatment and Follow-up

Congress has given the states an option for new federal funds for TB treatment and followup. Included in the federal budget bill passed in August 1993 is a five-year, $205-million outlay for Medicaid coverage of TB drugs and related services. The proposal, sponsored by U.S. Representative Henry Waxman (D-Calif), gained widespread support in both houses. In addition to prescription drugs for treatment and preventive therapy, the additional funds will cover services such as chest radiographs, home nurse visits, and outpatient followup. Coverage would begin January 1, 1994.

State health officials say the biggest advantage is coverage of directly observed therapy and case management services. Earlier this year, the CDC recommended that all TB patients be considered for DOT and receive an initial four-drug treatment regime.

Traditionally, the states have been responsible for budgeting TB care with their own funds. This bill would create a process to ensure supplemental funds. This does not mean that states can use federal funds to free state money for other things; rather, this is a supplemental funding based on need. The Health Care Financing Administration, which administers the federal portion of Medicaid, would develop a formula to distribute the funds where they are needed the most. New York will be high on the list: In 1992, it led the nation in TB incidence, with 25 cases per 100,000.

Another bill introduced in the Senate (S 1249) by Edward Kennedy (D-Mass) would allocate $200 million to the CDC for fiscal 1994 for prevention, control, and elimination programs; $26 million to the CDC for research, demonstration projects, and education and training; $46 million to the National Institute of Allergy and Infectious Disease for research; $5 million to the Food and Drug Administration for research, including the development of medication implant devices; and $25 million through the CDC to renovate hospitals and clinics that treat TB patients.

FROM: ***American Medical*** News. September 13, 1993; and ***AIDS Policy and Law.*** August 20, 1993.

## Hantavirus-Associated Illness Identified in North Dakota

On August 27, 1993, a previously healthy 14-year-old North Dakota boy died suddenly after a brief, unexplained febrile respiratory illness. Subsequent examination at CDC of specimens from this patient demonstrated the presence of serum immunoglobulin M antibody to the hantavirus antigens, a positive polymerase chain reaction assay for hantavirus genetic sequences in multiple tissue, and a positive immunohistochemical stain for hantavirus antigen in lung tissue, confirming the diagnosis of acute hantavirus infection. The patient had no history of recent travel outside the west north central region. An ongoing investigation of this illness is being conducted.

The recognition of this case in North Dakota, in addition to previously confirmed cases that have occurred outside the four-comers region of the Southwest, reinforces the need for clinicians throughout the United States to maintain a high index of suspicion for this condition and to inform health authorities of suspected cases. As of September 15, 36 cases have been confirmed in the United States.

## Malaria Diagnosed in 130 + U.S. Military Personnel Returning from Somalia

Malaria has been diagnosed in 48 U.S. military personnel who had onset of illness while in Somalia between December 1992 and April 1993, and in 83 additional military personnel following their return from Somalia (through June 1993). Of 53 investigated cases, ***Plasmodium vivax*** was detected in 41 of the cases, ***Plasmodium falciparum*** in nine, a mixed vivax and falciparum infection in two, and ***Plasmodium ovale*** infection in one. This substantial number of cases has reinforced concerns regarding malaria prophylaxis, and it underscores the need for prompt recognition and treatment of malaria in military personnel returning from Somalia and in other persons who have traveled to infested areas.

Mefloquine was used for malaria prophylaxis by 38 persons and doxycycline by 15 persons. Because of the reportedly low frequency of vivax and ovale malaria in Somalia, terminal prophylaxis with primaquine to prevent relapses of vivax or ovale malaria following departure was not recommended for Army personnel. Although terminal prophylaxis had been

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recommended for Marine and Navy personnel, only eight of the 15 Marines with vivax and ovale malaria had completed terminal prophylaxis. Prophylaxis was not supervised after returning to the United States and compliance was reportedly low. On May 21, 1993, the Office of the Surgeon General of the Army mandated primaquine as part of the terminal prophylactic regimen for troops returning from Somalia.

The probability of mosquito-borne transmission of malaria in the United States as a consequence of the return of these military personnel is considered low. From 1966 through 1972, four episodes of transmission in the United States, resulting in nine cases of malaria, were identified in association with the 13,843 military personnel subsequently diagnosed with vivax malaria in the United States after returning from Vietnam.

Prompt recognition and treatment of malaria is the most important approach for preventing introduction of malaria in the United States. The clinical presentation is often milder for patients who have continued taking prophylaxis or who have recently discontinued prophylaxis, compared with those patients who have not had any prophylaxis. Malaria infection can be excluded only after microscopic examination of serial thick and thin blood smears over a 72-hour period. Many of the cases of malaria described in this report by the CDC were characterized by a low density of parasitemia that was diagnosed only on thick smears. Physicians should report confirmed cases of malaria to their local health department and to the appropriate military medical authorities.

FROM: Malaria among U.S. military personnel returning from Somalia, 1993. ***MMWR*** 1993;42:524-*526.*

## AIDS-Related Claims Increase by $100 Million

An estimated $1.4 billion in AID&elated health and life insurance claims was paid by U.S. insurance companies in 1992, about $100 million more than in 1991, two insurance associations recently reported. These findings were from the seventh annual survey conducted by the American Council of Life Insurance and the Health Insurance Association of America. Individual accident and health claims remained the same as in 1991. This may have been related to improved medical management and better case management by insurers. Officials for the two associations said the survey may underestimate the AID&-elated claims because some claims may not describe treatment as being AIDS-related.

## WHO Estimates 13 Million HIV-Positive Women by the Year 2000

Speaking at the opening of the Second International Conference on HIV in Children and Mothers on September 7, 1993, in Edinburgh, Scotland, Dr. Michael Merson, Executive Director of the World Health Organization (WHO), said that by the year 2000, more than 13 million women will have been infected with HIV and about 4 million of them will have died. Merson outlined three primary reasons for the growth in HIV infection among women.

First, women are biologically more vulnerable. As the receptive partner, women have a larger mucosal surface exposed during intercourse. Moreover, semen contains a far higher concentration of HIV than vaginal fluid. Hence, women run a greater risk of contracting HIV and other sexually transmitted diseases.

Second, women are epidemiologically more vulnerable because they tend to marry or have sex with older men who have had more sexual partners and are more likely to be infected. Also, women in developing countries frequently require a blood transfusion during childbirth because of anemia or hemorrhage.

Third, women are socially more vulnerable because traditional norms and sexual subordination create an unfavorable atmosphere for AIDS prevention. This environment makes it difficult or impossible for women to protect themselves from sexual transmission through mutual fidelity or condom use.

In industrialized countries, transmission is still often through homosexual contact or injecting drug use, but there is an ominous rise in heterosexual transmission. In developing countries, heterosexual transmission has been predominant from the outset. In sub-Saharan Africa, women becoming infected with HIV now outnumber men 6 to 5, and the number of infected women continues to rise.

Merson concludes that "women face extra challenges in protecting themselves and their children from HIV infection, and prevention will take an alliance of men and women working together in a spirit of mutual respect."

**Additional news items in this issue:** ***OSHA Issues Guidelines for Enforcement of TB Protection Requirements*** (page 628), ***CDC Publishes Revised Guidelines for Preventing Transmission of Tuberculosis*** (page 641), ***International Conference on the Prevention of Infection*** (page 645).

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